34

34 Behavioral Health

Licensed psychologists and licensed social workers are enrolled for services provided to QMB recipients or to recipients under the age of 21 referred as a result of an EPSDT screening. Licensed counselors and licensed marriage and family therapists are enrolled only for services provided to recipients under the age of 21 referred as a result of an EPSDT screening. The policy provisions for psychologists can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

For those providers seeking to render ABA Therapy services, please refer to Chapter 37 Therapy (Occupational, Physical, Speech and ABA).

Federal regulations require that the State make provisions for handling of recoupments and recoveries. The Alabama Medicaid Agency will actively seek recovery of all misspent Medicaid funds and correctly paid benefits recoverable under Federal law; this statement will apply to the entire Alabama Medicaid Agency Provider Manual Chapter 34. For further understanding of recoupments, recoveries, and liens please refer to Alabama Medicaid Agency Administrative Code, Chapter 33.

The purpose of the recoupments, recoveries and liens effort is to assure that the State and Federal dollars allocated for medical assistance are spent only on those individuals who meet all eligibility criteria; to correct erroneous payments; and to recover benefits correctly paid, but recoverable by law; this statement will apply to the entire Alabama Medicaid Agency Provider Manual Chapter 34. For further understanding of recoupments, recoveries, and liens please refer to Alabama Medicaid Agency Administrative Code, Chapter 33.

34.1 Enrollment

Gainwell enrolls Psychologists and Behaviorial Health providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-validate periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-validate. Failure to re-validate and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-validate, providers will have to submit a new application for enrollment.

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National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a psychologist or behavioral health provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for behavioral health-related claims.

NOTE:
All ten digits are required when filing a claim.

Psychology providers are assigned a provider type of 54 (Psychologist). Valid specialties for psychology providers include the following:

- Psychology (112)
- QMB/EPSDT (600)

Behavioral Health providers are assigned a provider type of 07 (Behavioral Health). Valid specialties for behavioral health providers include the following:

- Licensed Professional Counselor / LPC (070)
- Associate Licensed Counselor / ALC (071)
- Licensed Marriage and Family Therapist / LMFT (072)
- Licensed Marriage and Family Therapist Associate / LMFTA (075)
- Licensed Master Social Worker / LMSW (073)
- Licensed Independent Clinical Social Worker / LICSW (074)
- Licensed Psychological Technician / LPT (076)
- QMB/EPSDT (600)

Enrollment Policy for Psychologists and Behavioral Health Providers

Psychology and Behavioral Health providers must meet the following requirements for direct enrollment and participation in Medicaid:

- **Psychologists** – must possess a doctoral degree in psychology from an accredited school or department of psychology; Have a current license issued by the Alabama Board of Examiners in Psychology to practice as a psychologist and operate within the scope of practice as established by the Alabama Board of Examiners in Psychology.
- **Professional Counselor** – must possess a masters degree (or above) in counseling from an accredited school; Have a current license issued by the Alabama Board of Examiners in Counseling to practice as a counselor (LPC, ALC) and operate within the scope of practice as established by the Alabama Board of Examiners in Counseling.
- **Marriage and Family Therapist** - must possess a masters degree (or above) in marriage and family therapy from an accredited school; Have a current license issued by the Alabama Board of Examiners in Marriage and Family Therapy to practice as a marriage and family counselor

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(LMFT, LMFTA) and operate within the scope of practice as established by the Alabama Board of Examiners in Marriage and Family Therapy.

- **Social Worker** - must possess a masters degree (or above) in social work from an accredited school; Have a current license issued by the Alabama State Board of Social Work Examiners to practice as a social worker (LMSW, LICSW) and operate within the scope of practice as established by the Alabama State Board of Social Work Examiners.
- **Psychological Technician** - must possess a masters degree (or above) in psychology from an accredited school or department of psychology; Have a current license issued by the Alabama Board of Examiners in Psychology to practice as a licensed psychological technician (LPT) and operate within the scope of practice as established by the Alabama Board of Examiners in Psychology. {Must maintain supervision requirements as outlined by the Alabama Board of Examiners in Psychology}.

To enroll as an Alabama Medicaid Behavioral Health Provider the service location must be a physical facility that is not a home residence, a cubicle located within an office space, or a shaped space inside another business. The physical facility must also have visible signage bearing the name of the business.

34.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Medicaid bases reimbursement of services on a fee for service for the procedure codes covered for behavioral health providers.

Behavioral Health services are only covered for QMB recipients (psychologists, licensed social workers), recipients referred directly as a result of an EPSDT screening (psychologists, licensed counselors, licensed marriage and family therapists) or recipients referred cascading by the psychologist (LMSW, LICSW). Treatment eligibility is limited to individuals with a diagnosis within the ICD-10 code range of F0150-F069 or F080-F099, assigned by a licensed physician, a licensed psychologist, a licensed physician's assistant, a certified registered nurse practitioner, a licensed counselor or a licensed marriage and family therapist as listed in the most current International Classification of Diseases.

The provider agrees when billing Medicaid for a service that the provider will accept as payment in full, the amount paid by Medicaid for that service, plus any cost-sharing amount to be paid by the recipient, and that no additional charge will be made. Conditional collections from recipients, made before Medicaid pays, which are to be refunded after Medicaid pays, are not permissible. The provider may not charge a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20). The provider (or its staff) must advise each recipient when Medicaid payment will not be accepted prior to services being

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rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted must be recorded in the recipient's medical record. If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., missed or canceled appointment.

Payments from Medicaid funds can be made only to providers of the services; therefore, no reimbursement can be made to patients who may personally pay for the service rendered.

NOTE:

Behavioral Health providers can bill only those procedures listed in Section 34.6.3, Procedure Codes and Modifiers. Only the diagnosis codes within the range of F0150-F069 or F080-F099 for ICD-10 are covered for treatment services under this program. Intellectual Disability diagnosis codes (F070-F079) are not covered for treatment services **except for Crisis Intervention (performed by a psychologist)**; however, Medicaid will cover diagnostic testing, status exam (96101-96103, 96116 and 96118-96120 even if the resulting diagnosis is Intellectual Disability.

NOTE:

Codes 90832, 90832+90785, 90834, 90834+90785, 90837, 90837+90785, 90846, 90847, 90849, and 90853 may be billed on a weekly basis; although limited to no more than 52 max units per year (combined).

***Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in the group above as per CPT® guidelines.**

The Alabama Medicaid Agency will not cover the following therapies as a stand-alone service:

- Equine assisted psychotherapy
- Biofeedback therapy
- Neurobiofeedback therapy
- Sleep therapy
- Dance therapy
- Music therapy
- Art therapy
- Play therapy

However, these therapies may be incorporated into the recipients counseling sessions for **no more than 50%** of the total time of the session. The start and stop time of each of the therapies (i.e. counseling vs alternative therapy) must be clearly documented. If the person administering one of the above therapies is different from the person providing the counseling, the name and credentials of that individual will need to be documented in the progress note as well as a copy of the credentials in the employee file.

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34.3 Service Provision

The Psychologist, LPC/ALC, and LMFT must receive a valid, completed EPSDT referral from the recipient's Primary Physician (PMP) in order to provide behavioral health services to a recipient. For additional information about the EPSDT referral form please refer to Appendix A Well Child Check-Up EPSDT.

In order to provide behavioral health services to a recipient, the LMSW or LICSW must receive an Alabama Medicaid Psychology (AMP) Referral form from an Alabama Medicaid enrolled psychologist or may directly receive an EPSDT referral for a recipient with a documented diagnosis.

Medical documentation must be present in the recipient's medical record identifying the psychologist making the referral. The AMP Referral is valid for a maximum of one year from the date that the referral is completed. The referring psychologists signature **and** number of visits or months approved must be documented on the referral in order for the form to be considered a valid referral.

The AMP Referral Form and instructions for completing can be found here: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.5_Health_Professionals/4.2.5.1_Psychologist_Billing.aspx.

Both the EPSDT and AMP Referral Form must be maintained on file and in the recipient's medical record.

Client Intake

An intake evaluation must be performed for each client considered for initial entry into any course of covered services. A fillable or printable version of this Medicaid approved tool (Diagnostic Intake Interview) can be downloaded at the following link: http://www.medicaid.alabama.gov/content/4.0_Programs/4.2_Medical_Services/4.2.5_Health_Professionals/4.2.5.1_Psychologist_Billing.aspx.

The intake evaluation process must include relevant information from among the following areas:

- Family history
- Educational history
- Medical history
- Educational/vocational history
- Psychiatric treatment history
- Legal history
- Substance abuse history
- Mental status exam
- Summary of the significant problems the client is experiencing

A comprehensive behavioral health assessment must be conducted whenever a behavioral health or developmental screening indicates the presence of a behavioral health symptom(s). For assessments that require

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certifications and/or trainings beyond the users education, the certification/training must be successfully completed **prior to** the use/administration of the chosen behavioral health assessment tool(s). Failure to possess the required certifications and/or trainings will subject the provider to program integrity action up to and including recoupment.. Examples of screening tools that can be used include, but are not limited to:

- Beck Depression Inventory and Child Behavior Checklist
- Behavior Assessment System for Children, 2nd Edition (BASC-2)
- Brief Symptom Inventory (BSI)
- Brown Attention-Deficit Disorder Scales
- Child and Adolescent Needs and Strengths (CANS)
- Childhood Autism Rating Scale (CARS)
- Children's Depression Inventory (CDI)
- Likert Scale
- Minnesota Multiphasic Personality Inventory (MMPI)
- Parent-Child Interaction Assessment-II
- State-Trait Anger Expression Inventory-2 , Child & Adolescent (STAXI-2 C/A)
- Wechsler Intelligence Scale for Children-Fourth Edition (WISC-IV)

Treatment Planning

The intake evaluation process must result in the development of a written treatment plan completed by the fifth client visit.

The treatment plan shall:

- Identify the clinical issues that will be the focus of treatment
- Specify those services necessary to meet the client's needs (Services are defined as the specific CPT® code descriptions as outlined on the grid in Section 34.6.3 Procedure Codes and Modifiers)
- Include referrals as appropriate for needed services
- Identify expected outcomes toward which the client and therapist will work to have an effect on the specific clinical issues
- The (initial) Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it. Unless clinically contraindicated, the recipient will sign or mark the treatment plan to document the recipient's participation in developing /revising the plan. If the recipient is under the age of 14 or adjudicated incompetent, the parent, foster parent or legal guardian must sign the treatment plan.

Services must be specified in the treatment plan in order to be paid by Medicaid. The treatment plan can be developed and carried out by the licensed social worker ***after*** diagnosis has been approved or received from the physician or psychologist practicing with their scope of practice.

The psychologist and/or behavioral health provider must review the treatment plan once every three months to determine the client's progress

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toward treatment objectives, the appropriateness of the services furnished, and the need for continued treatment. This review shall be documented in the client's clinical record by notation on the treatment plan. This review shall note the treatment plan has been reviewed and updated or continued without change. Treatment plans being carried out by an allied mental health provider must be reviewed/approved by the associated psychologist. **All** treatment plans must be updated annually. Treatment plan reviews should be conducted every 3-6 months to monitor progress.

Treatment plan review is not a face-to-face service, therefore the recipient/or legally responsible person signature is not required. The quarterly treatment plan review may be conducted by the Psychologist, Behavioral Health provider or by another professional with the same credentialing (or above), such as a supervisor or a peer. Only the reviewing professionals' signatures (handwritten or associated computerized electronic health record {not typed} signature) or initials and dates are necessary. A stamped signature is not acceptable.

Service Documentation

Documentation in the client's record for each session, service, or activity for which Medicaid reimbursement is requested must include, the following:

- The identification of the specific services rendered (Services are defined as the specific CPT® code descriptions as outlined on the grid in Section 34.6.3 Procedure Codes and Modifiers)
- The date and the amount of time (time started and time ended---excluding time spent for interpretation of tests---applicable to psychologists only) that the services were rendered
- The signature of the staff person who rendered the services
- The signature and date of the person rendering services and the client (if the client is a minor, the parent or legal guardian can sign for that minor).
- The identification of the setting in which the services were rendered
- A written assessment of the client's progress, or lack thereof, related to each of the identified clinical issues discussed
- All entries must be legible and complete, and must be authenticated and dated (***prior*** to being submitted for reimbursement) by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished. The author of each entry must be identified and must authenticate his or her entry. Authentication may include handwritten signatures, written initials (for treatment plan reviews), or computer entry (associated with electronic records—not a typed signature). A stamped signature is not acceptable.

The list of required documentation described above will be applied to justify payment by Medicaid when clinical records are audited. Payments are subject to recoupment when the documentation is insufficient to support the services billed. LPCs/ALCs and LMFTs no longer require psychologist signatures on any documents related to the treatment of a Medicaid recipient.

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Service Documentation Additional Information

To further clarify service documentation questions/issues, please note the following:

Documentation

Documentation must not be repetitive (examples include, but are not limited to the following scenarios):

- Progress Notes that look the same for other recipients.
- Progress notes that state the same words day after day with no evidence of progression, maintenance or regression.
- Treatment Plans that look the same for other recipients.
- Treatment Plans with goals and interventions that stay the same and have no progression.

Progress Notes

- Progress Notes must not be ***preprinted*** or predated.
- The progress note must match the goals on the plan and the plan must match the needs of the recipient. The interventions must be appropriate to meet the goals. There must be clear continuity between the documentation.
- Progress Notes must provide enough detail and explanation to justify the amount of billing.

Treatment Plan

- The Treatment Plan must not be signed or dated prior to the plan meeting date.
- The Treatment Plan is valid when the recipient/legally responsible person **and** the person who developed the plan sign and date it.

Authentication

- Authors must always compose and sign their own entries (whether handwritten or electronic). An author should never create an entry or sign an entry for someone else or have someone else formulate or sign an entry for them. If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. A stamped signature is not acceptable.

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- If utilizing a computer entry system, the program must contain an attestation signature line and time & date entry stamp. There must also be a written policy for documentation method in case of computer failure/power outage.

Corrections

- Corrections must be made legally and properly by drawing a line through the entry and making sure that the inaccurate information is still legible. Write "error" by the incorrect entry and initial. Do not obliterate or otherwise alter the original entry by blacking out with marker, using whiteout, or writing over an entry. White Out, Liquid Paper, or any form of correctional fluid or correctional tape is not acceptable on **any** records whether being used as a corrective measure or to individualize an original template or for any other reason.

Communication

- It is the responsibility of the provider to ensure that the primary care physician has been made aware of treatment plan goals by the fifth recipient visit, annually prior to EPSDT renewal; and, when requesting more than one therapy session per week. Documentation of communication will be required i.e. treatment note, fax confirmation sheet.

34.4 Prior Authorization and Referral Requirements

Psychology procedure codes generally do not require prior authorization. Any service warranted outside of these codes must have prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

A current completed Alabama Medicaid Agency Referral Form must be present in the patient's medical record that identifies the treated conditions referred as the result of an EPSDT screening or payments for these services will be recouped. The referral form must be current and appropriately completed by the screening physician including the date that the problem was identified and the reason for the referral. Refer to Appendix A Sections 4.2 – 4.6.

Signature Requirement for Referrals: Effective May 16, 2012:
For hard copy referrals, the printed, typed, or stamped name of the primary care physician with an original signature of the physician or designee is required. **Stamped or copied signatures will not be accepted**. For electronic referrals, provider certification is made via standardized electronic signature protocol.

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34.5 Cost Sharing (Copayment)

The copayment amount for office visit* including crossovers is:

$3.90 for procedure codes reimbursed $50.01 and greater
$2.60 for procedure codes reimbursed between $25.01 and $50.00
$1.30 for procedure codes reimbursed between $10.01 and $25.00

* The following CPT® codes are considered office visits and the copayment is based on Medicaid's allowed amount (fee schedule) for each procedure:

90847, 90849, 90853, 90865, 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

If one of these CPT® codes is applicable for your practice, then copay applies.

Copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, and family planning. Native American Indians that present an "active user letter" issued by Indian Health Services (IHS) will be exempt from the Medicaid required copayment.

The provider may not deny services to any eligible Medicaid recipient because of the recipient's inability to pay the cost-sharing (copayment) amount imposed.

34.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Behavior Health providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

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This section describes program-specific claims information. Providers should refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

34.6.1 Time Limit for Filing Claims

Medicaid requires all claims for Behavioral Health to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

34.6.2 Diagnosis Codes

The *International Classification of Diseases -10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field. Only the ICD-10 diagnosis codes within the range of F0150-F69 and F80-F99 are covered for services under this program.

34.6.3 Procedure Codes and Modifiers

The following procedure codes apply when filing claims for behavioral health services billed by a psychologist. The (837) Professional and Institutional electronic claims and the paper claim have been modified to accept up to four procedure code modifiers.

Claims without procedure codes or with invalid codes will be denied. Only the procedure codes/service descriptions listed in this section are covered under this program. Some codes are covered for QMB recipients only. Check the guidelines following this grid.

CPT® Code	*Description*	*See Note*	*Daily Max*	*Annual Max*
90791	Psychiatric diagnostic evaluation	1	1	1
90791 +90785	Psychiatric diagnostic evaluation with interactive complexity	1	1	1

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CPT® Code	***Description***	***See Note***	***Daily Max***	***Annual Max***
90832	Psychotherapy, 30 minutes (16-37*) with patient	3, 9	1	This group of procedure codes may be billed on a weekly basis; although limited to no more than 52 max units per year total (combined) *See footnote 12 *Exception: Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT guidelines.
90834	Psychotherapy, 45 minutes (38-52*) with patient	3, 9	1	
90837	Psychotherapy 60 minutes (53+*) with patient	2, 3	1	
90832 +90785	Individual psychotherapy, 30 minutes (16-37*) with patient with interactive complexity services	3, 9	1	
90834 +90785	Psychotherapy, 45 minutes (38-52*) with patient with interactive complexity services	3, 9	1	
90837 +90785	Psychotherapy, 60 minutes (53+*) with patient with interactive complexity services	2, 3	1	
90846	Family psychotherapy (without the patient present), 50 minutes (26+)	4, 9		
90847	Family psychotherapy (conjoint psychotherapy) with patient present, 50 minutes (26+)	4, 9	1	
90849	Multiple-family group psychotherapy	4, 9	1	
90853	Group psychotherapy (other than of a multiple-family group)	5, 9	1	
H2011	Crisis Intervention	11	4	1,460
PSYCHOLOGICAL TESTING EVALUATION SERVICES BY PROFESSIONAL				
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour**			5 units annually combined (with all related psychological

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CPT® Code	*Description*	*See Note*	*Daily Max*	*Annual Max*
96131	Each additional hour (List separately in addition to code for primary procedure)			testing codes)
TEST ADMINISTRATION AND SCORING BY PROFESSIONAL				
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, **first 30 minutes**			
96137	Each additional 30 minutes (List separately in addition to code for primary procedure)			
TEST ADMINISTRATION AND SCORING BY TECHNICIAN				
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; **first 30 minutes**			
96139	Each additional 30 minutes (List separately in addition to code for primary procedure)			

NEUROPSYCHOLOGICAL TESTING EVALUATION SERVICES BY PROFESSIONAL				
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; **first hour**			5 units annually combined (with all related neuropsychological testing codes)
96133	Each additional hour (List separately in addition to code for primary procedure)			
TEST ADMINISTRATION AND SCORING BY PROFESSIONAL				
96136	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, **first 30 minutes**			
96137	Each additional 30 minutes (List separately in addition to code for primary procedure)			
TEST ADMINISTRATION AND SCORING BY TECHNICIAN				
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; **first 30 minutes**			
96139	Each additional 30 minutes (List separately in addition to code for primary procedure)			

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96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgement, e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; **first hour**			
96121	Each additional hour (List separately in addition to code for primary procedure)			
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only		1	1

Reimbursable Codes for LPCs, LMFTs, LMSWs, LICSWs, and LPTs

The following codes are billable by the above named behavioral health professionals operating within their scope of practice. 90791 (billable by the **LPC/ALC, LMFT**, and **LMFTA**); 90832, 90834, 90837 (and with 90785 add-on for interactive complexity), 90846, 90847, 96130/96131, 96132/96133, 96138/96139, 96146.

LPTs: 90791, 96130, 96131, 96138 and 96139

The description, notes and daily/annual limitations apply as listed in the above grid, and as outlined below. It is the responsibility of the provider to keep up with any and all updates and/or changes to CPT® and/or HCPCS ® codes applicable to billing.

Individual psychotherapy codes should be used only when the focus of the treatment encounter involves psychotherapy. Psychotherapy codes should not be used as generic psychiatric service codes.

Guidelines for Covered Procedure Codes:

1. Codes 90791 and -90791+90785 have a combined annual max limitation of 1. The LICSW or LGSW may complete the Intake, but it must be reviewed **and** approved by the Psychologist, LPC/ALC or LMFT. This code is billable by the psychologist, LPT, LPC, LMFT, LMFTA and ALC **only**.
2. Please note 90837 / 90837+90785 are now the codes to be used to reflect 60 minutes of face-to-face time, and is included in the 52 unit annual max limitation.
3. Medicaid will not accept psychiatric therapy procedure codes 90832-90837 being billed on the same date of service as an E&M service by the same physician or mental health professional group.
4. Procedure codes 90847 and 90849 are used to describe family participation in the treatment process of the client. Code 90847 is used when the patient is present. Code 90849 is intended for group therapy sessions for multiple families when similar dynamics are occurring due

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to a commonality of problems in the family members in treatment. **Group therapy must be performed by a clinical psychologist licensed in the state of Alabama.** Group Therapy/Counseling progress notes must support that a process-oriented service involving group dynamics was provided.

Family therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When family therapy without the patient present (90846) or family therapy with the patient present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. These codes are now time based, 50 minutes and a minimum of 26 minutes must be documented in the start and stop time in order to be billed.

If there is more than one eligible child and no child is exclusively identified as the primary recipient of treatment, then the oldest child's recipient id number ***must*** be used for billing purposes. When a specific child is identified as the primary patient of treatment, that child's recipient ID number ***must*** be used for billing purposes. A family may be biological, foster, adoptive or other family unit.

A family is *not* a group and providers may *not* submit a separate claim for each eligible person attending the same family therapy session.

The therapist must document all attendees presence and participation.

All members of the family in attendance for the session will sign/mark the signature log or progress note to document their participation in the session (in addition to the therapist documenting their presence/participation).

5. Procedure code 90853 is used when psychotherapy is administered in a group setting with a trained group leader in charge of several clients. Personal and group dynamics are discussed and explored in a therapeutic setting allowing emotional catharsis, instruction, insight, and support. **Group therapy must be performed by a clinical psychologist licensed in the state of Alabama.** Group Therapy/Counseling progress notes must support that a process-oriented service involving group dynamics was provided. Group Therapy/Counseling for children and/or adolescents may not exceed 10 (ten) recipients.

6. **Professional and Technical Activities Performed by the Psychologist**

   Please note that the new codes do not cross-walk on a one-to-one basis with the deleted codes. The single code, 96101, will now be billed using up to four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring (96136, 96137).

   Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).

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- The first hour of evaluation is billed using 96130 and each additional hour needed to complete the service is billed with code add-on 96131.
- CPT® Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.

Evaluation services must always be performed by the professional prior to test administration, and must be billed on the last date of service, but documented in the medical record the actual date(s) the service is performed.
Test administration and scoring services **performed by the psychologist** includes time spent to administer and score a minimum of two (2) psychological tests.

- The first 30 minutes of test administration and scoring is billed using 96136 and each additional 30-minute increment needed to complete the service is billed with code 96137.
- CPT® time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

Professional Services Performed by the Psychologist and Technical Services Performed by Technician
Please note that the new codes do not cross-walk on a one-to-one basis with the deleted codes. The single code, 96102, will now be billed using four (4) codes; two (2) codes for Psychological Evaluation Services (96130, 96131) and two (2) for Test Administration and Scoring by Technician (96138, 96139).

Psychological Evaluation services include interpretation of test results and clinical data, integration of patient data, clinical decision making, treatment planning, report generation, and interactive feedback to the patient, family member(s) or caregiver(s).

- The first hour of evaluation is billed using 96130 and each additional hour needed to complete the service is billed with code add-on 96131.
- CPT® Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96130), at least an additional 31 minutes of work must be performed to bill the first unit of the add-on code 96131.

Evaluation services must always be performed by the professional prior to test administration, and must be billed on the last date of service, but documented in the medical record the actual date(s) the service is performed.
Test administration and scoring services **performed by the Technician** includes time spent to administer and score a minimum of two (2) psychological tests.

- The first 30 minutes of test administration and scoring is billed using 96138 and each additional 30-minute increment needed to complete the service is billed with code 96139.

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- CPT® time rules apply to the add-on code if, beyond the first 30 minutes, at least an additional 16 minutes of work is performed.

The units of measure for testing codes 96130 – 96131 has been changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore when billing claims .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers **cannot** bill less than a 30-minute increment. (*under daily max=combination of the codes).

Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary. A psychological technician with adequate training may directly provide services listed in the **Code of Alabama Governing Psychologists** Section 34-26-1 without supervision; the licensed psychologist must sign the report. A licensed psychologist must be on-site where an allied mental health professional is performing testing services within their scope of practice, and the licensed psychologist must sign the report.

7. Intellectual Disability diagnosis codes (ICD-10 F70-F79) are not covered for treatment services; however, Medicaid will cover diagnostic testing, status exam (96130/96131, 96136/96137,96138/96139, 96116 and 96132/96133, 96136/96137, 96138/96139), even if the resulting diagnosis is intellectual disability. The record must show the tests performed, scoring and interpretation, as well as the time involved (time started and time ended). Billing should document the **total** time for face-to-face administration, scoring, interpretation and report writing. The test(s) given on the date of service billed must be documented in the treatment note for post payment review purposes. When scoring, interpreting and report writing for test(st) that were administered by a BHP or an AMHP, the documentation must include: the total time spent completing the report, the actual date(s) and names of the test(s) administered as well as the name of the BHP or AMHP who administered the test for the specified recipient in the treatment note for post payment review purposes. The units of measure for testing codes 96132/96133 has been changed from a 1 hour measurement increment to a 30 minute measurement increment, therefore when billing claims .5 units will equal 30 minutes; 1 unit will equal 1 hour; 1.5 units will equal 1 ½ hours, etc. Providers **cannot** bill less than a 30-minute increment. (*under daily max=combination of the codes)

   Each test performed must be medically necessary; therefore, standardized batteries of tests are not acceptable. Nonspecific behaviors that do not indicate the presence of, or change in, a mental illness would not be an acceptable indication for testing. Psychological or psychiatric evaluations that can be accomplished through the clinical interview alone would not require psychological testing and such testing might be considered medically unnecessary. A psychological technician with adequate training may directly provide services listed in the **Code of Alabama Governing Psychologists** Section 34-26-1 without

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supervision; the licensed psychologist must sign the report. A licensed psychologist must be on-site where an allied mental health professional is performing testing services within their scope of practice, and the licensed psychologist must sign the report.

8. Code 96146 describes psychological/ neuropsychological testing by a computer. CPT® code 96146 includes a single automated psychological or neuropsychological instrument that is administered via electronic platform (e.g. computer) and formulates in an automated result. Only report 96146 for a single test administered via electronic platform. Do not report 96146 for administration of 2 or more tests and/or if test administration is performed by professional or technician. This code is billed only **once** as one service regardless of the number of tests taken or time spent by the recipient completing the test. The computer code is used only when the recipient is taking a computer-based test unassisted. This code can only be billed if the computer is used to score tests.

9. These procedure codes may be used in any combination for no more than 52 units total annually. Procedure codes 90846, 90847, 90849 and 90853 may be billed on the same date of service as other codes listed in this group as per CPT® guidelines. For exceptional circumstances where more than 52 units will be needed, consideration for request must be submitted.

10. Procedure Code 96116 is intended to describe the performance of gathering information to provide an important first analysis of brain dysfunction and progression and changes in the symptoms over time. This exam must include screening for impairments in acquired knowledge, attention, language, learning, memory, planning and problem solving, and visual-spatial abilities. This code has been revised and should no longer be billed in multiple units.

    This service includes an initial interview to collect clinical information prior to evaluation and test administration and scoring services.

    - The first hour of the exam is billed with CPT® code 96116 and each additional hour needed to complete the exam is billed using code 96121.

    CPT® Time Rules allow an additional unit of a time-based code to be reported as long as the mid-point of the stated amount of time is passed. Beyond the first hour (96116), at least an additional 31 minutes of work must be performed to bill additional unit(s) of the add-on code 96121.

Testing Codes Crosswalk

2018 CPT® Descriptor (Previous Code)	2019 CPT® Descriptor (Replacement Codes)
96101	96130
	96131
	96136

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	96137
96102	96130
	96131
	96138
	96139
96116	96116
	96121
96118	96132
	96133
	96136
	96137
96119	96132
	96133
	96138
	96139
96103 and 96120	96146

NOTE:

Psychological Testing codes 96130, 96131, 96136, 96137, 96138, and 96139 can be billed in any combination for a max of 5 units annually. Neuropsychological Testing codes 96132, 96133, 96136, 96137, 96138, and 96139 can be billed in any combination for a max of 5 units annually.

11. For consideration of lifting the maximum cap on weekly unit limitations, submit a cover letter, documentation of medical necessity **and** the exceptional circumstance (*i.e. how the recipient is an eminent danger to self or others and/or is at risk for hospitalization or decompensation*) along with the claim, related progress note(s) and cover letter to the following address:

    Associate Director, Mental Health Programs
    P.O. Box 5624
    Montgomery, AL 36103-5624

    A sample Psychologist Override Request form (that can be used in lieu of a cover letter) can be found at:
    http://www.medicaid.alabama.gov/documents/9.0_Resources/9.4_Forms_Library/9.4.11_Mental_Health/9.4.11_Psychology_Override_Request_Template.pdf

12. Crisis Intervention is defined as immediate emergency intervention performed only by **the psychologist** to ameliorate a client's maladaptive emotional/behavioral reaction. Service is designed to resolve the crisis and develop symptomatic relief, increase knowledge of where to turn for help at a time of further difficulty, and facilitate return to pre-crisis routine functioning.

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- Identifying the maladaptive reactions exhibited by the client
- Evaluating the potential for rapid regression
- Resolving the crisis
- Referring the client for treatment at an alternative setting, when indicated

1 unit=15 minutes; maximum billable units are 4 units per recipient per day; This code can also be performed (and reimbursed) for recipients with an Intellectual Disability, ICD-10 diagnosis codes (F070-F079).

13. "Billed on a weekly basis" means per calendar week (Sunday to Saturday).

14. It is the responsibility of the provider to keep up with any and all updates and/or changes to CPT® and/or HCPCS ® codes applicable to billing.

Use of Modifiers

Codes billed by an LPC, ALC, LMFT, LMFTA, LICSW, LGSW, LPT or with an HO modifiers will be reimbursed at 75% of the allowable amount.

Modifier 59 (Distinct Procedural Service)

Under certain circumstances eligible psychologist (and/or allied professional mental health staff) staff may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, not ordinarily encountered or performed on the same day by the same eligible psychologist (and/or allied professional mental health staff) staff. *However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.*

According to the CPT® book, modifier 59 is described as being necessary to describe a distinct procedural service. This modifier should only be used to show a distinct procedural service when a comprehensive/component coding pair is billed. Modifier 59 should not be billed to represent that multiple services of the same procedure code were performed.

A comprehensive/coding pair occurs when one code is considered a component procedure and the other code is considered a comprehensive procedure. These code pairs are frequently referred to as bundled codes thus meaning the component code is usually considered an integral part of the comprehensive code. Therefore, in most instances the most comprehensive code only should be billed and the component code should be denied as re-bundled or mutually exclusive.

Modifier 59 should only be used in conjunction with a comprehensive/ coding pair procedure when appropriately unbundling the code pair. This modifier 59 should not be billed with the comprehensive code. The component code can be unbundled or allowed separately, in certain situations. If the two

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services are performed at two different times of day, then modifier 59 can be submitted with the component procedure code.

In order to communicate the special circumstances of the component/ comprehensive code pair unbundling, diagnoses codes must be utilized as appropriate on the claim form. In some cases, it may be necessary to attach a detailed explanation of services rendered to further explain the reason for the unbundling of code pairs.

CMS publishes the National Correct Coding Initiative Coding Policy Manual for Medicare and Medicaid Services (https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html) and this may be used as a reference for claims-processing edits. The manual is updated annually, and the NCCI edits are updated quarterly. It is the responsibility of the provider to check the site quarterly for any billing related updates.

NOTE:

Procedure codes 90862, pharmacologic management, and 90865, narcosynthesis for psychiatric diagnostic and therapeutic purposes, **are covered for physicians only** and may not be performed or billed by psychologists.

34.6.4 Place of Service Codes

The following place of service codes apply when filing claims for behavioral health services:

POS Code	*Description*
03	School
11	Office
12	Home
21	Inpatient Hospital /(Psychologist Only)
22	Outpatient Hospital
23	Emergency Room – Hospital
31	Skilled Nursing Facility or Nursing Facility
32	Nursing Facility
51	Inpatient Psychiatric Facility (Psychologist Only)
52	Psychiatric Facility Partial Hospitalization
53	Community Mental Health Center
54	Intermediate Care Facility/Individuals With Intellectual Disabilities
55	Residential Substance Abuse Treatment Facility
56	Psychiatric Residential Treatment Center
72	Rural Health Clinic
99	Other Unlisted Facility

34.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

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NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

34.7 Covered Services Eligible for Telemedicine

Refer to Chapter 112, Telemedicine Services, for general information and limitations.

34.8 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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